



Cincinnati Retirement System

More,
for less...

40% OFF

Complete pair
of prescription
eyeglasses

20% OFF

Non-prescription
sunglasses

20% OFF

Remaining balance
beyond plan coverage

These discounts are for
in-network providers only

Hello,
Neighbor

- You're on the SELECT Network
- For a complete list of providers near you, use our Provider Locator on eyemed.com or call 1-866-299-1358.
- For Lasik providers, call 1-877-5LASER6, or visit eyemedlasik.com.

Vision Care Services

Exam With Dilation as Necessary

Contact Lens Fit and Follow-Up

Standard Contact Lens Fit & Follow-Up
Premium Contact Lens Fit & Follow-Up

Frames

Standard Plastic Lenses

Single Vision
Bifocal
Trifocal
Lenticular
Standard Progressive Lens
Premium Progressive Lens

Lens Options (paid by the member in addition to the price of the lenses)

UV Treatment \$15
Tint (Solid and Gradient) \$15
Standard Plastic Scratch Coating \$15
Standard Polycarbonate—Adults \$40
Standard Polycarbonate—Kids under 19 \$40
Standard Anti-Reflective Coating \$45
Polarized 20% off retail price
Other Add-Ons and Services 20% off retail price

Contact Lenses (Contact lens allowance includes materials only.)

Conventional \$0 Copay, \$100 Allowance, 15% off balance over \$100
Disposable \$0 Copay, \$100 Allowance, plus balance over \$100
Medically Necessary \$0 Copay, \$100 Allowance, plus balance over \$100

Laser Vision Correction

LASIK or PRK from U.S. Laser Network

Additional Pairs Discount

Frequency

Examination
Lenses or Contact Lenses
Frame

In-Network Member Cost

\$10 Copay

Up to \$40
10% off retail price

\$0 Copay, \$50 Allowance, 20% off balance over \$50

\$0 Copay
\$10 Copay
\$45 Copay
\$45 Copay
\$75
\$75, 80% of charge less \$120 Allowance

\$15
\$15
\$15
\$40
\$40
\$45
20% off retail price
20% off retail price

\$0 Copay, \$100 Allowance, 15% off balance over \$100
\$0 Copay, \$100 Allowance, plus balance over \$100
\$0 Copay, \$100 Allowance, plus balance over \$100

15% off the retail price or 5% off the promotional price

Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.

Once every 12 months
Once every 12 months
Once every 12 months

Out-of-Network Reimbursement

Up to \$100

N/A

N/A



What's in it for me?

Options. It's simple really. We love our members—that's why we are dedicated to helping you see clearly and we've built a network that gives you lots of choices and flexibility. You can choose from independent doctors and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy to use and to save you money. Welcome to EyeMed.



eyemed.com

Benefits Snapshot	With Us	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	\$10 Copay	Up to \$100
Frames (Once every 12 months)	\$0 Copay, \$50 Allowance; 20% off balance over \$50	Up to \$100
Single Vision Lenses (Once every 12 months) Or	\$0 Copay	Up to \$100
Contacts (Once every 12 months)	\$0 Copay, \$100 Allowance; plus balance over \$100	Up to \$100

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs \$163 with single vision lenses that have UV and scratch protection. Now let's see the difference . . .

**67%
SAVINGS
with us**

	With Us	Without Insurance**
Exam	\$10 Copay	Exam \$106
Frame	\$163 <u>-\$50 Allowance</u> \$113 <u>-\$22.60 (20% discount off balance)</u> \$90.40	Frame \$163
Lens	\$0 Copay \$15 UV treatment add-on <u>+\$15 Scratch coating add-on</u> \$30	Lens \$78 \$23 UV treatment add-on <u>+\$25 Scratch coating add-on</u> \$126
Total	\$130.40	Total \$395

Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered—fund as a Bifocal lens.

Benefit allowance provides no remaining balance for future use within the same benefit year. Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. **Based on industry averages.



LENSCRAFTERS®

